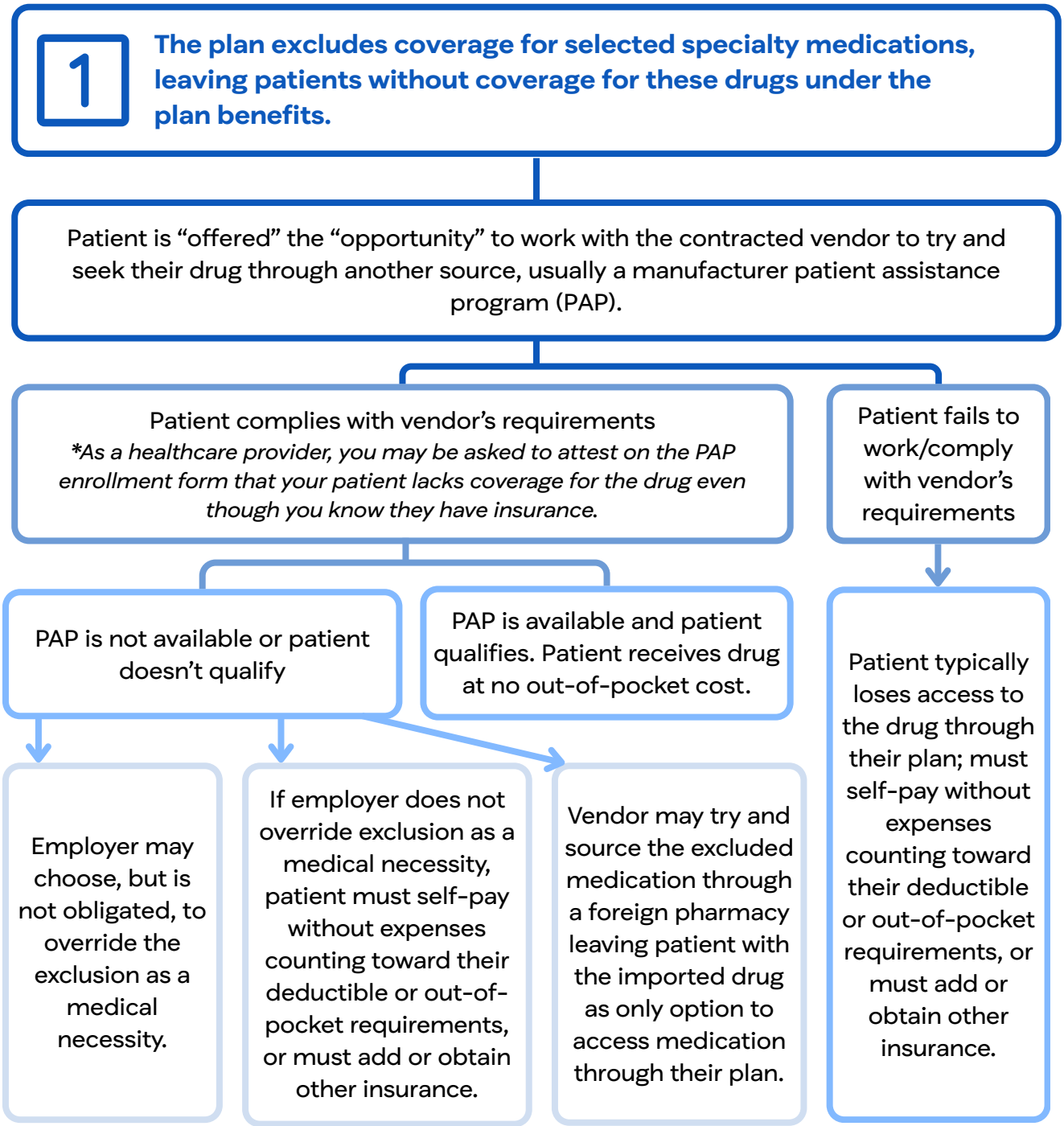
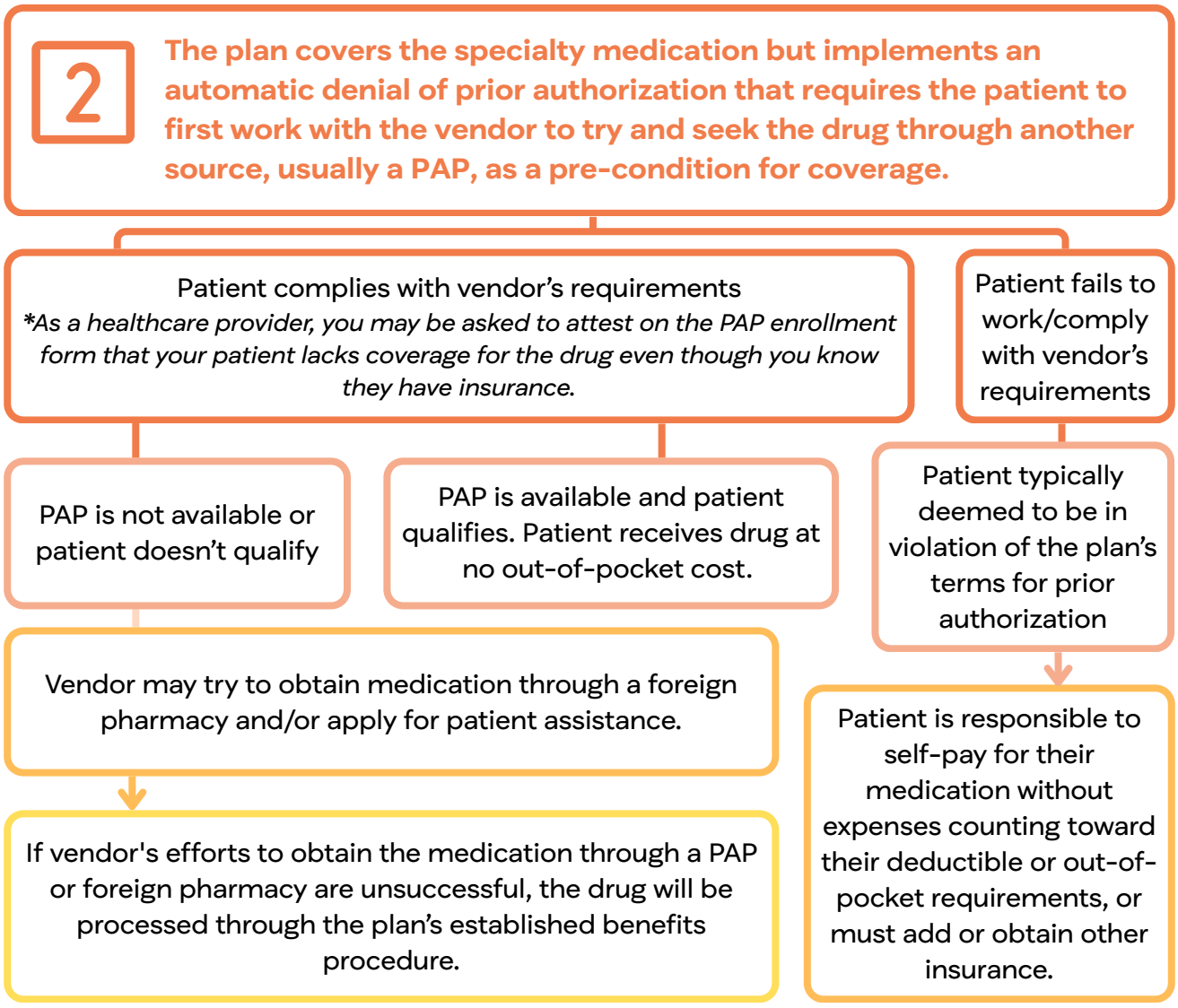
Understanding Alternative Funding Programs, Copay Accumulators, and Copay Maximizers: A Resource for Healthcare Professionals

What are Alternative Funding Programs (AFPs)?

AFPs are programs designed by third-party, for-profit vendors marketed to self-funded employer health plans as a cost-avoidance measure for specialty medications. AFPs typically work by manipulating the plan design in one of two ways:





In both AFP scenarios, the medication is first sought from a manufacturer PAP, which is intended to serve as a safety-net program for patients with limited or no insurance. Misuse of these finite resources could result in a lack of options for those without other means of accessing treatment.

AFPs are generally identifiable by the requirement that patients engage and comply with the third-party vendor trying to source the specialty medication through a PAP or, if the PAP proves unsuccessful, sourcing the drug from a foreign pharmacy.

Key Takeaway: AFPs target the **sourcing of the drug itself**, with a goal of eliminating or reducing specialty drug spending for employers, by taking advantage of manufacturer free drug programs (PAPs). To do so, **employers require patients to work with AFP vendors** without choice, or they are left to pay for these medications out of pocket.

Contrasting AFPs from copay accumulators and copay maximizers

What are copay accumulator programs?

- Copay accumulator programs are health plans' or pharmacy benefit managers' (PBMs) directed policies that permit patients to use third-party copay assistance for **covered drugs** without counting that assistance towards a patient's deductible or out-of-pocket cost-sharing requirements.

- Once a patient has exhausted the available third-party copay assistance, the patient remains responsible for paying their entire deductible and all other out-of-pocket cost-sharing requirements as if no third-party copay assistance has been collected by the plan/PBM.

Copay accumulator programs allow health plans/PBMs to collect duplicate financial payments from both third-party copay assistance programs AND from the patient.

Key Takeaway: Copay accumulator programs target available copay assistance funds without allowing those dollars to count toward a patient's cost sharing requirements.

What are copay maximizer programs?

- Copay maximizer programs are a tactic used by health plans/PBMs to "maximize" the value of third-party copay assistance (typically manufacturer copay assistance) available for a particular **covered drug** in a plan year. Unlike copay accumulator adjusters, copay maximizers do not require the patient to pay out of pocket for the covered drug as long as they enroll in the program. Copay maximizer programs work by the plan/PBM **designating a drug as a covered non-essential health benefit** (covered non-EHB) and then setting the patient's required annual copayment for that drug equal to the maximum amount of available manufacturer financial assistance in that plan year, an amount that may exceed permissible patient cost-sharing protections under the Patient Protection and Affordable Care Act (ACA).

- This potentially higher deductible and maximum out-of-pocket requirement is distinct to the covered non-EHB drug, with none of these assistance funds counting towards the plan's standard deductible or maximum out-of-pocket. [i]Copay maximizers are implemented by the plan/PBM, requiring the patient to enroll in the program through a third-party administrator before they are permitted to fill that prescription under the terms of the plan. If the patient does not enroll in the copay maximizer program, they will be responsible for 100% of the cost of their drug.

- Once the third-party copay assistance has been exhausted, the patient typically has no remaining liability for this drug; however, due to its designation as a "covered non-EHB", nothing paid for this drug counts towards the deductible or maximum out of pocket for the patient's other covered services. **Like copay accumulators, copay maximizer programs target funds used to help pay for the drug.**

Key Takeaway: Copay maximizers designate a **covered prescription drug as a non-essential health benefit** to eliminate the ACA's cost-sharing protections so the plan/PBM can collect the maximum available amount of third-party copay assistance for the plan year without counting any of that assistance towards a patient's deductible or out-of-pocket cost-sharing requirement.

[i] The 2025 Notice of Benefit and Payment Parameters (NBPP) recognized that defining all specialty drugs as non-EHBs would likely not be consistent with ACA.

Similarities and Differences Between AFPs, Copay Accumulators, and Copay Maximizers

	Copay accumulators	Copay maximizers	AFPs
Third-party assistance	Plan/PBMs implement copay accumulator policies to collect third-party financial assistance on behalf of patients for drugs covered by the plan.	Plans/PBMs use copay maximizers to collect the maximum amount of available manufacturer financial copay assistance in a plan year, often an amount more than the ACA's permissible patient out-of-pocket maximum.	AFPs are focused on the sourcing of the medication itself, usually targeting manufacturer patient assistance programs (PAPs).
Essential Health benefit	Specialty drugs are considered covered essential health benefits (EHBs).	Plans/PBMs designate the drug as a covered non-essential health benefit.	Self-funded employer plans do not have to cover essential health benefits.
Financial assistance strategy	Financial assistance is sought to help offset a plan's cost of covering a medication.	Financial assistance is sought to help offset a plan's cost of covering a medication.	AFPs seek a plan's total cost avoidance for a specialty medication by attempting to leverage other entities to provide the patient with the drug itself for free with no direct cost to the plan.

	Copay accumulators	Copay maximizers	AFPs
Coverage of medication	Requires coverage of the medication for which a plan/PBM is collecting third-party financial copay assistance.	Requires coverage of the medication for which a plan/PBM is collecting third-party financial copay assistance.	An AFP using the automatic denial of prior authorization tactic **requires plan coverage** of the specialty drug the vendor is trying to obtain through another source. Conversely, the other AFP tactic specifically **excludes coverage** of the specialty medications.
Counting third-party assistance	Does not count any of the collected third-party financial copay assistance towards the patient's deductible or out-of-pocket cost sharing requirements.	Does not count any of the collected third-party financial copay assistance towards the patient's deductible or out-of-pocket cost sharing requirements. Regardless of enrollment in the program, none of the assistance dollars will count toward their deductible or out-of-pocket cost-sharing requirements.	Patients subject to either type of AFP who fail to work/comply with a vendor must self-pay the full cost of their medication with none of those paid amounts counting towards their deductible or out-of-pocket cost sharing requirements, or add or obtain other insurance.

How AFPs negatively impact patients

- Devalues the patient's health plan and their required premium contributions by the plan's failure/refusal to provide timely coverage of prescribed medications
- Delays/denies access to needed medications, potentially worsening the patient's condition/disease
- May expose patients to non-FDA-regulated imported drugs and their potential harms
- May interfere with provider treatment decisions, including non-medical switching of medications
- Depletes safety-net programs intended for uninsured or underinsured patients
- Targets patients with serious, complex, or chronic conditions requiring timely receipt and use of prescribed specialty medication
- Exerts undue pressure on patients, resulting in increased stress and anxiety
- Places patients in untenable positions, that could result in possible legal jeopardy
- Increases patients' costs and eliminates patients' cost-sharing protections
- Requires patients to provide sensitive financial, personal, and health information, and a limited power of attorney to a third party

Sharing your experience as a healthcare provider is important

We would like to learn more about how AFPs are impacting your patients and their access to needed treatment. Please share your story by scanning this QR code.

Communication between healthcare providers and patients can help uncover AFPs

Engaging in dialogue with your patients and asking the right questions can help identify when AFPs are at play. Here are examples of questions you might consider asking your patients:

- Have you had difficulty filling your prescription?
  (If your patient says yes, ask why!)
- Has your plan excluded your drug or denied prior authorization for your medication?
- Have you been told you must work with a third-party vendor and/or must apply for manufacturer PAP to be able to access your medications?
- Have you been asked to provide tax returns, pay stubs and/or a limited power of attorney to this vendor?
- Have you been told by this vendor that they will try to secure your medication through a manufacturer's patient assistance program or another source?
- Have you been asked to obtain or import your medication from an international pharmacy?
- Have you been asked to participate in a telehealth call with a healthcare provider from outside the United States?
- Have you been asked to travel to another country to obtain your prescription?

Open enrollment: A key time for patients to ask questions

Encourage your patients to ask questions of plans during Open Enrollment. They should know whether the plan they are considering excludes their medications and works with alternative funding programs.

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